POLICIES AND PROCEDURES **State of Tennessee Department of Intellectual and Developmental Disabilities**	**Policy #: 90.1.1**	
Policy Type: Intermediate Care Facilities for Persons with Intellectual Disabilities	**Effective Date: March 23, 2012**	
Approved by: **Commissioner**	**Supersedes: NONE** **Last Review or Revision:**	
Subject: Nursing Health Care Management		

I. **AUTHORITY:** Tennessee Code Annotated 4-4-103, Tennessee Code Annotated 4-3-2708, Tennessee Code Annotated 33-3-101, Section 1905 (d) of the Social Security Act, 42 CFR 483.420 through 480.

II. **PURPOSE:** The purpose of this policy is to provide consistent patient safety standards in department Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/ID), and the Harold Jordan Center (HJC).

III. **APPLICATION:** This policy applies to all health care providers and nursing staff licensed to practice in Tennessee, that are employed in department ICFs/ ID or the HJC.

IV. **DEFINITIONS:**

A. **Abnormal Involuntary Movement Scale (AIMS)** shall mean an instrument used to detect and monitor abnormal movements associated with Tardive Dyskinesia (TD) in individuals treated with antipsychotic or other neuroleptic drugs.

B. **Assessment** shall mean a systemic collection of data.

C. **Braden Scale** shall mean a risk assessment to evaluate the potential for developing pressure ulcers.

D. **Circle of Support (COS)** shall mean a group of people who meet together on a regular basis to help a person, who is supported, plan for and accomplish his or her personal outcomes and actions. The person supported is the focus or the center of the COS. At a minimum, the COS includes the person, his or her family member(s) and or conservator(s) or legal representative, a QDDP case manager, and the providers of any supports and services that the person receives. Friends, advocates, and other non-paid supports are included in the COS at the invitation of the person supported or their legal representative.

E. **Dyskinesia Identification System Condensed User Scale (DISCUS)** shall mean an instrument used to detect and monitor abnormal movements associated with Tardive Dyskinesia (TD) in individuals treated with antipsychotic or other neuroleptic drugs.

F. **Enteral Feeding Tubes** shall mean tubes such as gastrostomy tubes (G tubes), jejunostomy tubes (J tubes), and gastrostomy/jejunostomy tubes (GJ tubes) that are medically inserted into persons who are unable to take in enough food or drink through the mouth.

G. **Glascow Coma Scale (GCS)** shall mean a neurological scale that aims to give a reliable, objective way of assessing the conscious state of a person.

H. **Health Care Plan** shall mean a plan of care developed by a health care provider from an analysis of health related data that identifies specific outcomes with accompanying interventions.

I. **Health Care Provider** shall mean a licensed individual who is responsible for developing the health care plan after gathering and analyzing health-related data, identifying outcomes, and designing interventions. The health care provider is also responsible for ensuring the implementation of the health care plan as well as conducting periodic reviews and or revisions of the health care plan.

J. **Health Care Surveillance** shall mean the continuous, systematic collection, analysis and interpretation of health related data needed for the planning, implementation, and evaluation of the health of a person or a group of persons.

K. **Health Risk Screening Tool (HRST)** shall mean an instrument used by trained licensed nurses to identify the person's health care risk level. Levels are rated using the following categories: (1) Functional Status, (2) Behavior, (3) Physiological, (4) Safety, and (5) Frequency of Service. Based on the person's risk factors in these categories, a risk level is assigned, ranging from one (1) through six (6).

L. **Health Surveillance** shall mean observations, data collection, analysis, and the use of devices to record a process or activity.

M. **Individual Support Plan (ISP)** shall mean a person centered document that provides a comprehensive description of the person supported as well as guidance for how to accomplish unique outcomes that are important to the person in achieving a good quality of life in the setting in which the person resides.

N. **Interventions** shall mean the selection of strategies based on the knowledge that certain actions produce a desired effect. Interventions are planned, safe, legal, and compatible with medical orders.

O. **Licensed Nurse** shall mean a person currently licensed as a licensed practical nurse (LPN) or licensed registered nurse (RN) by the Tennessee Board of Nursing.

P. **Outcomes** shall mean personal outcomes that are centered on the person supported, not on programs or program categories. The focus is on the items and issues that matter most to the person. Organizations that are working on personal outcomes recognize the connections between services, supports, interventions, and the person.

Q. **Patient Safety Standards** shall mean an approved model that is data driven, and is practical to implement and administer with a person centered approach. These standards encompass leadership commitment and support, performance improvement actions and results, and creativity and innovation.

R. **Primary Care Provider (PCP)** shall mean the terminology used interchangeably in reference to a person's physician, advanced practice nurse, or physician assistant.

S. **Tardive Dyskinesia (TD)** shall mean a mostly irreversible neurological disorder of involuntary movements caused by use of antipsychotic or neuroleptic drugs.

V. **POLICY:** It is the policy of the department to ensure that evidence based health care assessments are comprehensive, timely, accurate, and reflect good health care management practices and processes regardless of setting (i.e., ICF/ID or HJC). Interventions shall be person centered and inclusive of supports needed to increase independence of the person supported.

VI. **PROCEDURES:**

A. General Guidelines

1. The leadership in ICFs/ID and HJC are accountable for all components of patient safety.

2. All ICFs/ID and the HJC shall ensure that all employees and health care staff receive initial orientation and periodic updated training on patient safety standards.

3. All ICFs/ID and the HJC shall maintain a record system for all persons supported in accordance with Policy #204 Uniform Individualized Record, as amended.

4. The record system shall have capability for the immediate retrieval of information necessary for the health care and or primary care provider to review historical health information as well as document current health information.

B. Nursing Assessments

1. All assessments shall be reviewed and signed by an RN.

2. All assessments shall be documented on approved forms.

3. All assessments and components shall be performed according to required time frames.

4. The initial, annual, and quarterly assessment shall include (if applicable), but are not limited to, the following:

a. Patient interview (including family, caregiver(s), conservator or legal representative) regarding current and past history, family history, food and drug allergies, and medication history.

b. Health problems.

c. General health conditions.

d. Social life and well-being.

e. Laboratory data and diagnostic test results.

f. Physical exam, including vital signs, blood pressure, pulse, respirations, oxygen saturation, temperature, current height and weight.

g. HRST.

h. Braden Scale.

i. AIMS or DISCUS.

j. Cumulative seizure record.

k. Elimination records.

l. Menstrual records.

m. Incidents, including hospitalization, emergency department visits, and reportable medical.

n. Cumulative height and weight record.

o. Glascow Coma Scale.

p. Health record review from the date of the previous assessment.

q. Vaccine and immunization record.

5. Initial assessments shall be completed within thirty (30) calendar days of admission to the ICF/ID or HJC.

6. Quarterly assessments shall be completed ninety (90) days from the initial assessment and every ninety (90) days thereafter up to the date of the annual assessment.

7. Annual assessments shall be completed within thirty (30) calendar days of the Independent Support Plan (ISP) effective date.

8. Assessments shall be completed upon the person's return from hospitalization, outpatient procedures, surgery, emergency care visits, and whenever there is a change in the person's health status.

9. Problem oriented assessments shall include baseline data and a systems review in accordance with Tennessee Best Practice Guidelines, and assessment standards of care.

C. Health Surveillance

1. Health surveillance frequency shall be based upon interventions and assessment outcomes.

2. Documentation and reporting of health surveillance activities shall be completed in accordance with standards of care.

3. Any abnormal finding or outcome shall be reported to the PCP.

4. The above notification shall be documented in the person's health record.

D. Health Risk Screening Tool (HRST)

1. The HRST shall be completed by a licensed, trained nurse who has demonstrated competence in administration and scoring.

2. The HRST shall be reviewed and updated at least thirty (30) calendar days prior to Individual Support Plan (ISP) or individual transition plan meetings.

3. The HRST and health care plan shall be reviewed and updated within ten (10) business days following a change in health status, such as but not limited to the following:

    a. Acute hospital admission.

    b. Significant change in health status.

    c. Behavioral destabilization.

    d. Loss of functional skills.

4. The Circle of Support shall ensure the following health management outcomes, taking into consideration the person's health care risk level and the RN's recommended health care services.

    a. Level of health care and nursing supports.

    b. Level of health care surveillance.

    c. Staff training.

E. Braden Scale

1. The Braden Scale shall be completed by a licensed, trained nurse who has demonstrated competence in administration and scoring.

2. Each person shall have an initial Braden Scale established upon admission to the ICF/ID or HJC, and when a Braden Scale has not been previously established.

3. Each person shall have a Braden Scale completed quarterly, annually, and when there is a change in health status.

4. The Braden Scale and health care plan shall be reviewed and updated within ten (10) business days following a change in health status, such as but not limited to the following:

    a. Acute hospital admission.

    b. Significant change in health status.

    c. Behavioral destabilization.

    d. Loss of functional skills.

5. The Circle of Support shall ensure the following health management outcomes, taking into consideration the person's Braden Scale Risk Score, and the RN's recommended health care services.

    a. Level of health care and nursing supports.

    b. Level of health care surveillance.

    c. Staff training.

F. Nursing Practice Guidelines and Procedures

1. Clinical Nursing Skills and Techniques by Anne Griffin Perry and Patricia A. Potter shall be the accepted text for performing nursing procedures, as revised.

2. Tennessee Best Practice Guidelines shall be the accepted nursing guidelines, as revised.

3. Exceptions to the accepted text include:

    a. Licensed practical and registered nurses shall not, in any circumstance, manipulate a J tube or GJ tube by advancing or pulling back.

    b. Licensed practical and registered nurses shall not, in any circumstance, reinsert a J tube or GJ tube.

    c. Unlicensed staff shall not manipulate enteral feeding tubes in any way, but shall immediately report any concerns regarding enteral feeding tubes to licensed nurses.

G. Communicating and Documenting Medical Orders

1. All medical orders (i.e., order) shall be written on a physician order sheet, prescription form, or approved electronic form and signed by the treating practitioner.

2. All licensed disciplines are responsible for ensuring that allergies are documented in the person's health record.

3. Only approved abbreviations and or symbols shall be used.

4. Expressions of resume pre-op orders, routine orders, or post hospitalization orders are not acceptable.

5. Each order shall specify the following:

    a. Time, date, and year.

    b. Patient name.

    c. Route of administration.

    d. Frequency and duration.

e. Indication.

6. Pre-test orders shall specify the period of time of pre-test administration (e.g., one (1) hour before electroencephalogram).

7. The treating PCP shall legibly print and sign his or her name and credential.

8. All orders resulting from a consultation shall follow the same procedural guidelines.

9. The licensed staff writing the order(s) shall be responsible for flagging any new order, thus ensuring the order is addressed.

10. All verbal orders shall be authenticated by 'read-back' to the PCP, who shall immediately verify the order is correct. Documentation of the 'read-back' shall be recorded on the medical order to include the date, time and signature.

11. Verbal orders shall be signed by the prescribing PCP within fourteen (14) business days of issuing the order.

12. New orders shall be written and carried out as soon as possible, unless the PCP directed the order be started **STAT**.

13. Each ICF/ID site and HJC shall have a written, well defined decision tree process describing the completion and communication of all orders.

14. Within twenty-four (24) hours of receiving a new medical order a licensed nurse shall conduct a chart review, cross-reference **all** orders, and shall verify that **all** orders are complete and accurate.

15. The nurse shall document the date and time of the chart review on the order.

16. The nurse shall immediately notify the PCP upon discovery of any discrepancies and shall also ensure that any discrepancies are rectified.

VII. **ATTACHMENTS:** None